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ABSTRACT

This monograph presents a brief guide to definitions, diagnosis, and treatment of attention deficit disorders (ADD) in children. Attention deficit disorder is defined and its relationship to hyperactivity explained. A chart summarizes four types of ADD (hyperactive/impulsive/aggressive, mixed, inattentive/passive, and pseudo ADD) in terms of characteristics, causes, school problems, diagnosis, treatment, and prognosis. Diagnosis and etiology are then addressed. Multimodal treatment of ADD is recommended involving educational, counseling, medical, and parent training components. Thirteen strategies are offered to help the ADD student. These include: simplify directions; modify the task; structure the child's space; communicate closely with parents; place the child in a highly structured classroom; personalize goals for the inattentive child; establish a secret signal to remind the child to return to the task; implement individual coaching; and have the child eat high protein breakfasts. Attached are a sample form for recording a 2-week high protein breakfast trial, a fact sheet on attention disorders, and a daily report card and reinforcement form. (DB)

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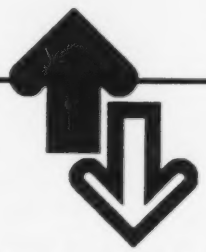
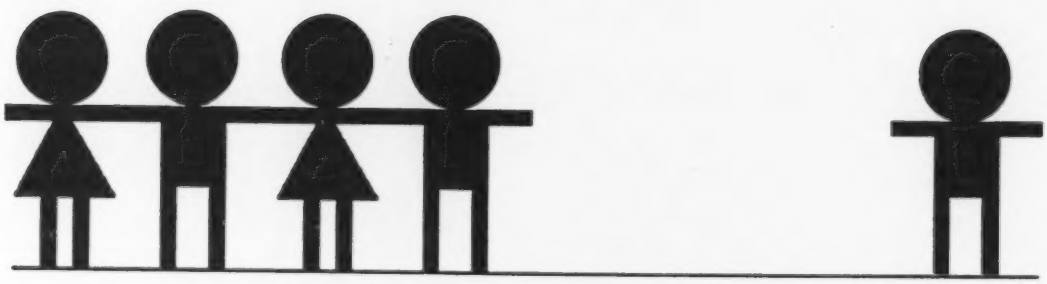
Children with Attention Disorders in School



A descriptive guide for parents and teachers



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What is Attention Deficit Disorder?

Attention Deficit Disorder (ADD) is an early childhood condition which is characterized by significant pervasive primary symptoms including:

1. Inattention/Distractibility
2. Impulsivity
3. Hyperactivity

ADD is a chronic disorder which can begin in infancy (or even in utero) and can extend through adulthood while having negative effects on a child's life at home, school, and within his/her community. It is conservatively estimated that 3-5% of our school age population is affected by ADD, a condition which previously fell under the heading of "learning disabled" "brain damaged", "hyperkinetic", or "hyperactive". However, the newer term, attention deficit disorder, was introduced to more clearly describe the characteristics of these children. Two types of ADD are differentiated in clinical diagnosis, both of which are described below.

Attention Deficit Hyperactivity Disorder (ADHD)

According to the criteria in the Diagnostic and Statistical Manual (1987) of the American Psychiatric Association, to diagnose a child as having ADHD s/he must display for six months or more at least eight of the following characteristics before the age of seven.

1. Fidgets, squirms or seems restless
2. Has difficulty remaining seated
3. Is easily distracted
4. Has difficulty awaiting turn
5. Blurts out answers
6. Has difficulty following instructions
7. Has difficulty sustaining attention
8. Shifts from one uncompleted task to another
9. Has difficulty playing quietly
10. Talks excessively
11. Interrupts or intrudes on others
12. Does not seem to listen
13. Often loses things necessary for tasks
14. Frequently engages in dangerous actions

Non-Hyperactive or Undifferentiated Attention Deficit Disorder

In this form of ADD the primary and most significant characteristic is inattentiveness; hyperactivity is not present and thus it is more of a hidden handicap. Nevertheless, these children still manifest problems with organization and distractibility and they may be seen as quiet or passive in nature. It is speculated that Undifferentiated ADD is currently under diagnosed as these children tend to be overlooked more easily in the classroom.

School Related ADD Categories

The primary symptoms of ADD (i.e., inattention, impulsivity and hyperactivity) can occur in various forms of behavior and in various combinations; nevertheless, all the primary symptoms (or any one of them) manifest themselves as "problem behavior" in the school setting. There are four types of ADD that seem to occur within the school setting that have important differences in terms of char-

FOUR TYPES OF ADD FOUND IN THE SCHOOL SETTING

	Characteristics	Causes	School Problems	Diagnosis	Treatment	Prognosis
TYPE 1 **Hyperactive Impulsive Aggressive**	• pervasive problems in all settings (home/school) • all primary symptoms inattentive (sustained ADD) impulsive hyperactive (aggressive forms of hyperactive/impulsive behavior) • poor self control "immature" and uninhibited	• suspected neuro-developmental, e.g., neuro transmitter dys-function (Dopamine) • aggressive behavior learned through coercive parenting and poor impulse control • increased incidence associ ated with prenatal drug exposure	• learning disabilities (50 to80%) • handwriting and written work delays common • behavior problems/disruptive - fighting - verbally abusive/noisey - grabby • social behavior prob-blems moderate to severe; secondary emotional problems • school failure	• observations in any setting • easily diagnosed if hyper since or before birth •psychological assess-ment necessary to rule out possible learning disorder (LD) • pediatrician should refer to psychiatrist if possible	• medication often "tried" early. In addition, other combinations of inter-ventions and treatments may be necessary: - behavior management - counseling - parent training - parent support group - special education - diet management	Prognosis is very poor unless practically all possible interventions or treatments are effect-ively employed. Conduct disorder, oppositional disorders and criminal behavior is prevalent in adolescence with this type
TYPE 2 **Mixed**	• moderate to severe for child and school • more problematic at school than home, i.e., "situational" • primary symptoms in varying degrees and combinations • described as "immature" • appear uninhibited • sustained ADD • not persistant	• neuro developmental • situational demands exacerbate symptoms e.g., school and other situations that demand attention/concentration	• learning disabilities present 25-50% • various L.D. processing weakness may be present, i.e., audio, video, and/or motor • secondary emotional problems and social adjust-ment problems • school failure	• pervasive history since pre school time • clinical evaluation sometimes • frequently referred for special education assess-ment • should be evaluated by school team even when LD symptoms absent	"multimodal" as needed. Unless severe problems are present, start with non-drug approaches: 1. generic strategies 2. behavior management 3. parent training 4. diet management 5. counseling 6. special education Medication when above doesn't work or are impractical	Unless agressive behavior is evident, prognosis is fairly good if proper treatment is delivered. Job and social adjustment tend to be below par as adults
TYPE 3 **Inattentive-Passive**	• mild to moderate for child and school • "ADD without hyperactivity" • situational and even task specific • work habit problems; social behavior usually adequate • appear to have hearing problems, but don't • Focused ADD (FADD)	• neuro-developmental plus situational demands • organic factors are still considered causative as with Types 1 and 2	• 20% LD • often have LD problems involving auditory processing, e.g., memory discrimation and audio figure-ground • underachievers • can result in school failure • associated self esteem problems • poor listening skills	• more subjective than types 1 and 2 • pervasive history of work habit problems at school • full assessment by school team necessary even when LD symptoms absent • cannot be diagnosed before age 8 • Longitudinal diagnosis often necessary	• never start with medication • use "least restrictive" approaches - generic strategies - behavior management -diet management - parent training • Special Education (if eligible) • medication when all else fails/low dosage	Good prognosis with corrective treatment. (Research not available to confirm this prediction) This form of ADD recog-nized only since 1980 as a disorder. Research needed.
TYPE 4 **Pseudo A.D.D.**	• mild to severe for child, fa nily and school • ADD symptoms in various forms are present but transitional, i.e., child has good days and bad days	• situational • emotional e.g., anxiety or depression • can have biochemical origins, e.g., neurotrans-mitter dysfunction (Serotonin) or pre diabetic condition effects. • avoidance reaction to frustration (easily frustrated)	• 5 to 10% LD i.e., like general population • work habit problems and poor concentration • inappropriate social behavior can be problematic • SED • Behaviorally disturbed	• school assessment desirable to rule out true ADD • clinical confirmation desirable along with clinical treatment	• school treatment: behavior management • refer for counseling • medication for depression or anxiety (e.g., Tofranil, Norpramin, Buspar) • stimulant medication contra-indicated: Pre psychotic condition or tic disorders (Tourette)	Variable prognosis; depends upon severity of emotional involvement and causes which can be both situational and bio-chemical. Proper diagnosis and treatment is needed, especially therapy and medication, if needed.

acteristics, school problems, treatment and prognosis. The various types of ADD are differentiated in chart form on the previous page.

How is ADD Diagnosed?

Students who have exhibited the characteristics mentioned above for longer than six months may be at risk for having an attention deficit disorder. However, a diagnosis of attention deficit should only be made after ruling out other factors related to medical, emotional or environmental variables which could cause similar symptoms, e.g., childhood depression or anxiety disorder. Therefore, physicians, psychologist, and educators often conduct a multi-disciplinary evaluation of the child including medical studies, psychological and educational testing, speech and language assessment, neurological evaluation, and behavioral rating scales completed by the child's parents and teachers. A health and developmental history reported by parents that shows evidence of primary symptoms noted during the preschool years is very important information to obtain in the diagnostic process.

In the school setting, the ADD child can demonstrate significant problems that take the form of learning disabilities, inappropriate social behavior, and/or work habit problems. The ADD child is obviously "at risk" for failure at school and this child will often be referred for psycho-educational assessment. The school psychologist is often in the position of coordinating the psycho-educational assessment process and has access to crucial information in order to accurately diagnose the child with ADD symptoms. Critical information regarding a particular student comes from the following sources: health and development history, school records (e.g., cumulative file), classroom observations, observations in testing, psychometric data, and parent/teacher behavior rating scales.

A thorough evaluation of a child suspected of ADD should be conducted within the school setting by a multi-disciplinary team comprised of the regular education teacher, special education teacher, school psychologist and a speech therapist. The assessment information is gathered and documented by the school psychologist in a psycho-educational report which will recommend appropriate treatment for the student in question.

What are the causes of Attention Deficit Disorders?

A 1987 Report to Congress prepared by the Interagency Committee of Learning Disabilities attributes probable cause of ADD to "abnormalities in neurological function, particular to disturbance in brain neurochemistry involving a class of brain neurochemicals termed 'neurotransmitters'." Researchers are unclear, however, as to the specific mechanisms by which these neurotransmitter chemicals influence attention, impulse control and activity level. In the past fifty years there have been incidences of childhood diseases that affect brain chemistry (e.g., encephalitis) which produced ADD symptoms in otherwise normal children. At the present time (1990) we

are looking at a whole new group of children entering school with ADD. In these ever increasing number of cases, the cause of ADD is due to prenatal drug exposure, including alcohol, cocaine, amphetamine and heroine addiction by their mothers.

Although many ADD children tend to develop secondary emotional problems, ADD, in itself, may be related to biological factors and is not primarily an emotional disorder. Nevertheless, emotional and behavioral problems can frequently be seen in ADD children due to problems that these children tend to have within their school, home, and social environments. Such characteristics as inattentiveness, impulsivity, and underachievement can also be found in ADD students who suffer primarily from emotional difficulties which affect concentration and attentiveness and performance (i.e., pseudo ADD). Differential diagnosis, therefore, is an essential prerequisite to effective treatment.

What is the treatment for ADD?

Treatment of the ADD child usuallyrequires a multi-modal approach frequently involving a treatment team made up of parents, teachers, the school psychologist, physicians, and behavioral or mental health professionals. Various forms of treatment include the following:

A. Educational
(School-based treatment)
1. Generic classroom strategies
2. Special education programs
3. Behavior Management

B. Counseling (parent and child)
1. Demystification
2. Cognitive behavioral therapy (CBT)
3. Parent support groups

C. Medical (pediatrician, psychiatrist, neurologist)
1. Medication
   a. Stimulants (e.g., Ritalin)
   b. Anti-depressants (e.g., Trofranil)
2. Diet management
   a. High protein breakfast
   b. Allergy control

D. Parent training (home based)
1. Parent training in behavior management
2. Deliver medical treatment
3. Follow through of home/school monitoring
4. Counseling

Without appropriate treatment, ADD can cause school failure, rejection by peers and family turmoil, all of which can lead to developmental delays and psychiatric complications stemming from low self-esteem and frustration. The prognosis is particularly poor for those children that develop aggressive behavior in addition to the primary symptoms of ADD. The worst form of ADD (aggressive) can often lead to oppositional, antisocial and criminal behavior.

How is medication used in the treatment of Attention Deficit Disorders?

The use of medication alone in the treatment of ADD is not recommended. As indicated earlier, a multimodal treatment plan is usually followed for successful treatment of the ADD child or adolescent. While not all children having ADD are prescribed medication, in certain cases the proper use of medication can play an important and necessary part in the child's overall treatment.

Ritalin, the most commonly used medication in treating ADD, is a psychostimulant and has been prescribed for over 30 years with very favorable results and minimal side affects. Other psychostimulant medications which are used to treat ADD are Cylert and Dexedrine. In the past several years antidepressant medications such as Tofranil and Norpramin have also proved successful in treating the disorder. All these medications are believed to affect the body's neurotransmitter chemicals, deficiencies of which may be the causeof ADD. Improvements in such characteristics as attention span, impulse control and hyperactivity are noted in approximately 75% of children who take psychostimulant medications. It is important that teachers are informed about all medications that an ADD student may take as teachers need to work closely with the child's parents and other helping professionals in monitoring medication effectiveness.

Medication side effects such as appetite loss, sleep difficulties, and/or lethargy in the classroom, among others, can often be controlled through medication dosage adjustments when reported by the child's parents or teachers.

What strategies can be used to help the ADD student?

The most effective treatment of ADD requires full cooperation of teachers and parents working closely with other professionals such as physicians, psychologists, psychiatrists, speech and educational specialists, etc. In the coordinated effort to ensure success in the lives of children with ADD the vital importance of the teacher's role cannot be overestimated. Dennis Cantwell, M.D. claims, "Anything else is a drop in the bucket when you compare it with the time spent in school."

A child with attention problems has the greatest difficulty in being able to narrow the focus of attention. S/he is like a camera with the lens wide open. Every stimulus streams into their awareness equally and simultaneously.

Thus, s/he is the victim of an assault on their senses by everything in their vicinity, including color, sound, movement, confusion and emotionally charged situations. This child requires extra time to adapt to the myriad of sensations in a new experience. Consider some of the following generic strategies in helping the inattentive/ distractible child learn more effectively:

1. <u>Simplify directions:</u> Expect the inattentive child to have difficulty following directions. Give directions one step at a time; these students have extreme difficulty remembering three-step directions. Give directions orally, visually (on the board) and have them write them down.

2. <u>Modify the task:</u> Shorten or break up the assignment so that it becomes manageable for the child.

- cut the assignment in half.
- only do the odd numbered problems.
- draw a line where to stop, etc.

Try to give feedback, and especially positive strokes, for attempting all the (modified) task upon completion of that segment of the task. Remember, these children need feedback more frequently by completing parts of a bigger task and appropriately asking for feedback upon completion of a segment.

3. <u>Structure their space</u>
   a. Reduce normal distractions for the inattentive child through the use of a 3-panel screen or study carrel or call it a "work corner". This space should not be used as a "time out". Offer the space as a privilege or something any student could try to help them concentrate and get their work done. It should not be used as a punishment.

   b. Define spatial boundries for the kid who is constantly "out of seat". To control out of seat behavior of a hyperactive child, use a visible tape on the floor around the student's desk. State the rule: "You can't go beyond the lines or you'll have to pay" (a response cost).

4. <u>When nothing seems to be working (especially the student) use your own plan:</u> Consider using a predetermined alternative activity when the child is particularly unfocused, e.g.,errand to the office, lap around the playground, alternative task for 10 minutes, etc. The idea is to give the child a choice or a break from a difficult task, at least temporarily, and to prepare them to come back to that difficult task once the alternative has been accomplished--"When you come back, you'll be twice as ready to work again." And, please, try not to be sarcastic.

5. <u>Change the task more frequently:</u> Motor activities, especially, should be alternated with quiet intellectual ones. These children are restless, have real difficulty with impulse control. Their needs for large muscle activities or such releases as music should be channeled, not suppressed.

In this way, they will not think of themselves as irritating or "bad" because they are unable to sustain effort for one thing for as long as other children do. Moreover, they will not be as irritating.

The strategy of changing the task frequently is specifically used by some special education class teachers in conjunction with learning centers, i.e., the task is changed every 15 minutes.

6. **Communicate closely with parent(s):** Frequent communication with the parent is often necessary as part of the process of helping the attention disordered child. One way to have positive home-school contact is through the use of a daily or weekly behavior feedback report.

A good note home can be a powerful reinforcer for a child. Any reportsystem should be kept very simple but specifically tailored to the problem behaviors of the unfocused student, e.g., on-task behavior, task completion, talk outs, out of seat, etc. consider the use of ON-TASK cards or Happy-Face cards for young children. For serious problems of inattention, consider the use of the Home-School Management Plan. Ask your school psychologist for more information. It's simple and it works quite well with some students.

7. **Classroom Placement that is highly structured:** The inattentive child needs more external structure than most students. Consider a classroom set up along the lines of the Assertive Discipline model:

- clear rules regarding student behavior (do's and don'ts)
- rules are visible (posted)
- clear and reasonable consequences for breaking the rules are evident
- positive consequences are used for individual and group effort.
- teacher is consistent in operation of the plan (i.e., delivers the consequences
- there's a consistent class routine
- classroom is fairly quiet during work time

8. **Establish a personalized goal for the inattentive child:** For example, a goal to improve time on-task or task completion are often a desirable goal for unproductive inattentive student.

Attention problems are a serious handicap in the classroom. Show the student you understand the problem. Find out the average amount of time the student is able to stay on-task (a minute, 5 minutes, 10?). Make the student aware of this information. Ask the child to set a goal for him or herself: "Can you double this amount of time on-task by the end of the quarter?" (by the end of February?). Put the goal in writing. Use a kitchen timer to determine actual improvement.

9. **Secret signal:** Establish a secret signal to remind or cue the student to return to the task at hand. Be sure to

give them your attention (i.e., praise, touch, etc.) when they are on-task. Possible signals: a nod, a secret word, e.g., "Michael, glopnish" (which is a polite way of telling Michael to get back to work), or sometimes a glance or eye contact can be an appropriate signal.

10. Adjust the task: Even though a child can do a task at a certain level, often the inattentive child cannot do the task independently. Make the task easy to do independently (i.e., a level below his/her skill level). This helps establish independent work habits.

Other ways of making the task more appropriate or easier to accomplish is to place them in a lower group within the classroom or in another classroom (if necessary). Sometimes grade placement (retention) determination is necessary, especially if the child is inappropriately placed for all academic subjects at the primary grade levels.

11. Color grounding: Use a piece of construction paper in the student's favorite color as a desk blotter. Tell him/her that it will help to focus their attention. Who knows, sometimes the power of suggestion as well as the "placebo effect" can produce beneficial results.

A related color grounding technique has been effective with some children by using color transparencies to focus on reading tasks. Try experimenting (or have the student experiment) with different colored transparencies. Finding the right color can reduce "scotopic sensitivity" in some children.

12. Coaching: A little bit of individual coaching may be necessary for the inattentive/distractible child. The childrenoften recognize and are especially sensitive to their own limitations; they become easily frightened and discouraged in new situations; therefore, a little training beforehand can often greatly help put these children at a level where they can complete more adequately. This kind of coaching is legitimate. Remember, these kids (unless hyperactive) have a hidden handicap.

13. The Breakfast Effect: There is some convincing evidence that demonstrates that what children eat for breakfast can affect their level of concentration at school (Conners, 1989). A breakfast with protein (e.g., milk and cereal) is much preferred to carbohydrate-sugar combination (e.g., pancakes and syrup). Parent and teacher cooperation and communication is important here. The parent will have to "experiment" with a high protein breakfast and check with the teacher to help determine its effect.

The Two Week High Protein Breakfast Trial

SUGGESTED HIGH PROTEIN FOODS
for the
INATTENTIVE CHILD
A.M. FEEDING

BREAKFAST

____ cooked eggs - whole wheat toast

____ cooked eggs - meat

____ cooked eggs -cheese

____ cold cereal - whole milk (all milk consumed)

____ peanut butter on whole wheat toast
or whole wheat waffle (jelly ok)

____ protein powder and milk (e.g., Instant Breakfast)

____ flavored yogurt on whole wheat waffle

SNACK

____ 2 handfuls of unsalted peanuts with 1 handful of raisins

____ peanut butter and jelly sandwich

____ string cheese

- DON'T EAT MORNING FOODS CONSISTING OF PRIMARILY CARBOHYDRATES AND SUGAR (e.g., pancakes and syrup)
- Call teacher on Thursdays to see if the protein at breakfast helps improve concentration at school.
- Write on calendar what child ate for breakfast.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				Call teacher about behavior		
				Call teacher about behavior		

FACTS ABOUT ADD (Demystification)

Attention Disorders

by Richard Morriss, Ph. D.
School Psychologist

PRIMARY SYMPTOMS:
1. Inattention/distractable
2. Impulsive
3. Hyperactive

PROBLEMS:

- The primary symptoms of Attention Deficit Disorder (ADD) can occur in any combination and to any degree; sometimes hyperac-tivity is only mild or not a problem.
- Even in its mildest forms, ADD can interfer significantly with learning; work habits and/or social behavior; therefore, ADD can cause all sorts of problems for the child at school.
- Associated problem behaviors include:
  doesn't finish work
  doesn't seem to listen
  easily distracted
  problems of sustained attention
  acts without thinking
  constantly shifts activities
  poorly organized
  needs supervision
  talks out
  out of seat
  fidgety/squirmy
  can be restless & overactive
  learned agressive behavior
- These problem behaviors are usually a bigger problem at school than at home.

CAUSES:

It's generally agreed that ADD is a physically-based disorder. However, the specific nature of its physical basis is still open to scientific investigation. A dysfunction in "neurotransmitter metabolism" has been postulated as one cause of ADD, while central nervous system immaturity and specific developmental trauma (e.g., head injury, prenatal drug exposure, etc.) have also been considered as a possible cause.

PARENTS:

- Parents may notice ADD symptoms in their children as early as infancy and toddlehood. Teachers often describe ADD children as restless, inattentive, easily distracted and overly-impulsive.
- Frustrated, upset and anxious parents do not cause their children to have ADD. On the contrary, ADD children usually cause their parents to be frustrated, upset and anxious.
- When aggressive behavior is also a problem, special parent training is recommended.

FACTS:

- It's estimated that 3% to 5% of the population of children in the United States are ADD. Boys are anywhere from three to nine times more likely to have ADD than girls. If the incidence is only 3%, there is still one child in every classroom with the disorder.
- In school, ADD children may have problems organizing their work, listening to directions, writing neatly, and finishing their assignments. However, when they are particularly interested in something like a movie or computer program, ADD kids have no trouble at all paying attention.
- Of course, not all children who exhibit these symptoms do so as a result of a true attention deficit disorder. Disorganized home or school environments, emotional difficulties within the child, or lack of motivation can cause similar symptoms. The difference for ADD children is that under normal conditions, they lack the physical ability to control their behavior; this is the bio-physical nature of the true ADD child.
- It is important to know what ADD is not. It is not a form of mental retardation. ADD children usually are of at least average intellectural potential; many are more than average. They are not primarily emotionally distrubed children; although, many will develop emotional problems. The emotional problems these children have do not cause the academic difficulties; the academic difficulties cause the emotional problems.
- ADD occurs across all cultures, ethnics and socioeconomic levels as a physiological disorder.
- Children with ADD are more easily identified when hyperactivity is a prominent symptom. When hyperactivity is not a prominent symptom, diagnosis is more difficult.
- ADD is often (at least 50%) associated with learning disabilities (LD). ADD can cause a learning disability and LD can precipitate ADD symptoms; the later is not true ADD.
- Children with ADD are more easily identified when hyperactivity is a prominent symptom. When hyperactivity is not a prominent symptom, diagnosis is more difficult.
- ADD children who develop aggressive behaviors like fighting, stealing and lying often (at least 50%) exhibit serious conduct problems in adolescence and anti-social behavior as adults.

THE TREATMENT FOR ADD

The common forms of treatment for ADD are listed below. ***Combinations*** of treatments are often necessary. Medication is usually recommended for children with moderate to severe forms of ADD so that other treatments are maximally effective.

A. Educational (School-based treatment)
   1. Generic classroom strategies
   2. Special education programs
   3. Behavior Management

B. Counseling (parent and child)
   1. Demystification
   2. Cognitive behavioral therapy (CBT)
   3. Parent support groups

C. Medical (pediatrician, psychiatrist, neurologist)
   1. Medication
      a. Stimulants (e.g., Ritalin)
      b. Anti-depressants (e.g., Trofanil)
   2. Diet management
      a. High protein breakfast
      b. Allergy control

D. Parent training (home-based)
   1. Parent training in behavior management
   2. Deliver medical treatment
   3. Follow through of home/school monitoring
   4. Counseling

Without appropriate treatment, ADD can cause school failure, rejection by peers and family turmoil, all of which can lead to developmental delays and psychiatric complications stemming from low self-esteem and frustration. The prognosis is particularly poor for those children that develop aggressive behavior in addition to the primary symptoms of ADD. The worst form of ADD (aggressive) can often lead to oppositional, anti-social and even criminal behavior.

References:

Coleman, Wendy. Attention Deficit Disorders, Hyperactivity and Associated Disorders: A Handbook for Parents and Professionals (5th edition). Madison, Wisconsisn: Callipe Books, 1988.

Conners, C. Keith. Feeding the Brain: How Foods Affect Children. New York: Plenum Press, 1989.

Ingersoll, Barbara. Your Hyperactive Child: A Parents Guide to Coping with Attention Deficit Disorder. New York:Doubleday, 1988

Nichamen, Samuel J. and Wendel, James. Coping With Your Inattentive Child.

Silver, Larry. The Misunderstood Child: A Handbook for Parents with Childern with Learning Disabilities. New York: McGraw 1985

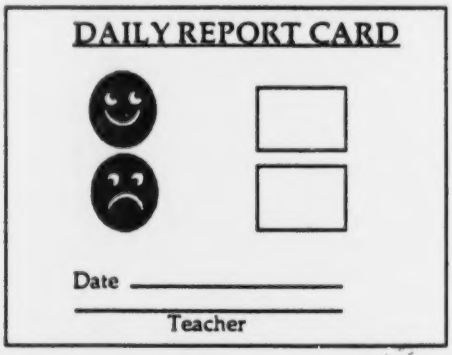
Weiss, G., and Hechtman, L. Hyperactive Children Grown Up. New York: The Guilford Press, 1986.

B.M. Sample 1:

(Kindergarten through 3rd grade)

The Daily Report Card and the Bedtime Agreement

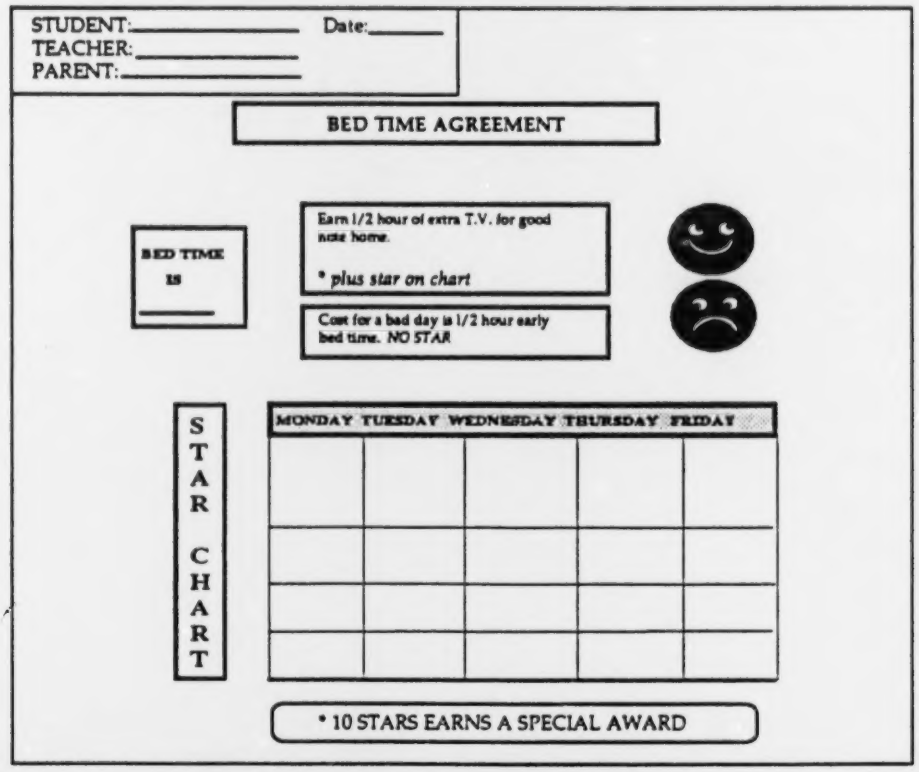
Teacher issues daily report card to student. This system uses a daily report card like the one below to inform the parent if the child was able to



Teacher supply:
Use the DAILY REPORT CARD (4 to a page) as shown in APPENDIX

demonstrate specified targeted behavior (e.g., completed work, stayed in seat, followed directions, cooperated, etc.)

The parent must follow through with the Bedtime Agreement which is self-explanatory.


STUDENT:
Date:
TEACHER:
PARENT:
BED TIME AGREEMENT
BED TIME IS
Earn 1/2 hour of extra T.V. for good note home.
* plus star on chart
Cost for a bad day is 1/2 hour early bed time. NO STAR
STAR CHART
MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY
* 10 STARS EARNS A SPECIAL AWARD

References

Coleman, Wendy. Attention Deficit Disorders, Hyperactivity and Associated Disorders: A Handbook for Parents and Professionals (5th edition). Madison, Wisconsin: Calliope Books, 1988.

Conners, C. Keith. Feeding The Brain: How Foods Affect Children. New York: Plenum Press, 1989.

Ingersoll, Barbara. Your Hyperactive Child: A Parents Guide to Coping with Attention Deficit Disorder. New York: Doubleday, 1988.

Morriss, Richard. Attention Disorders in School Age Children: The Role of the School Psychologist in Diagnosis and Treatment. P.O. Box 2496, Carmel Valley, CA 93924.

Nichamen, Samuel J. and Wendel, James. Coping With Your Inattentive Child. Waterford, MI: Minerva Press, 1985.

Silver, Larry. The Misunderstood Child: A Handbook for Parents with Children with Learning Disabilities. New York: McGraw Hill, 1985.

Weiss, G., and Hechtman, L. Hyperactive Children Grown Up. New York: The Guilford Press, 1986.

Wender, Paul H. The Hyperactive Child, Adolescent and Adult: Attention Deficit Disorder Through the Lifespan. New York: Oxford University Press, 1987.